STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005096	A. BUILDING: _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN ST ELIZABETH HEALTH - LAFAYETTE I	1701 S CREASY LN LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a State complaint survey. Complaint Number: IN00184952 Substantiated; no deficiencies related to the allegations are cited. Survey Date: 12-03-2015 Facility Number: 005096 Franciscan St. Elizabeth Health - Lafayette East, was found in compliance with Hospital Licensure Rules 410 IAC 15-1.5-8, Physical plant, maintenance and environmental services. QA: cjl 01/27/16	S 000		